PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

PLEASE PRINT INFORMATION

Name	FIRST MIDDLE LAST			**Date:**	
Date of Birth:				**Age:**	
Gender:	☐ M ☐ F	**Race:**		☐ **Hispanic** ☐ **Non-Hispanic**	
Currently Employed:	☐ NO ☐ YES	**Occupation:** (Current OR Previous)			
Marital Status:	☐ **Married**	☐ **Divorced**	☐ **Widowed**	☐ **Single**	

CONTACT INFORMATION:

Primary Phone:				**Type:** ☐Home ☐Cell ☐Work ☐Other	
Secondary Phone:				**Type:** ☐Home ☐Cell ☐Work ☐Other	
Email Address:				**SS :**	___-___-____
Street Address:				**Apt #:**	
City:		**State:**		**Zip:**	

EMERGENCY CONTACT INFORMATION:

Name:		**Relationship:**	
Phone:		**2nd Phone:**	

ALLERGIES (medication, food, other)

Allergy:	**Reaction:**

Indication of Study:	
Referral Source:	

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

Name:	Date of Birth:

Please list below any surgeries, hospitalizations, seizure history, cancer or other significant medical events / diagnoses that you have had. We need **AT LEAST** your best guess for the year of each date.

Condition / Event	Date Diagnosed	Date Resolved	Continuing?	Treated with Medication?

Please list below any medications you currently take, or have taken in the past 3 months.
We need AT LEAST your best guess for the year of each date.

Medication	Indication	Dose	Frequency	Route	Start Date	Stop Date	Continue? Y or N

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

Name:	Date of Birth:

Please list below any pharmacies you may have used in the past 3 years:

Name	Address	City / Town	Phone	Fax

Please list below any doctors you have seen in the past 5 years:

Name	Specialty	Address / City	Phone	Fax

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

Name:	**Date of Birth:**
Tobacco Use:	
Have you ever smoked / used tobacco products?	€Yes €No
If **yes**, do you currently smoke / use tobacco products? Specific product: Average daily consumption:	€Yes €No
If **no**, when did you stop? (please give at least the year)	
Caffeine / Stimulant Consumption:	
Do you currently consume caffeine or xanthenes or other stimulants? Specific product: Average daily consumption:	€Yes €No
Alcohol Consumption:	
Do you currently consume alcohol?	€Yes €No
If Yes: What is your average weekly consumption of beers (1 beer = 12oz)?	
If Yes: What is your average weekly consumption of wines (1 wine = 5oz)?	
If Yes: What is your average weekly consumption of spirits (1 spirit = 1.5oz)?	
Recreational Drug Use:	
Have you ever used recreational drugs?	€Yes €No

If Yes: Please check all that apply and date last used:

€Amphetamine _____	€Phencyclidine _____
€Barbiturate _____	€Inhalant _____
€Cannabinoid _____	€Hallucinogens _____
€Cocaine _____	€Controlled Substance Analogs (Designer Drugs) _____
€Opiate _____	€Other (_____) _____

PRINCETON

PSYCHIATRIC CENTERS, PA

Woodlands Professional Building
256 Bunn Drive, Suite 6
Princeton, New Jersey 08540
Telephone: (609) 683-7111
Facsimile: (609) 921-3620

CREDIT AUTHORIZATION FORM

Account Name: _____

Account Number: _____

Credit Card: _____

Expiration Date: _____

CVC Code: _____

I hereby authorize Princeton Psychiatric Centers to charge my credit card in the amount of _____, for the services rendered.

Cardholders name _____

Signature _____

Date _____

Date of service _____

******Keep on file for future visits x_____

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

☐ I hereby authorize Dr. Jeffrey T. Apter and/or his staff to contact my physician to request information concerning any medical information available regarding my health records.

☐ I, the undersigned, hereby authorize and request you to release and/or send my records as indicated below:

Patient Name (Please Print): _____

Patient Signature / Date: _____ / _____

Guardian Signature / Date: _____ / _____
(If patient is a minor)

Physician's Name: _____
Area of Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____

Physician's Name: _____
Area of Specialty: _____
Address: _____
_____
Phone: _____
Fax: _____

PLEASE MAIL / FAX THE REQUESTED INFORMATION TO:

PRINCETON PSYCHIATRIC CENTER
WOODLANDS PROFESSIONAL BUILDING
256 BUNN DRIVE, SUITE 6
PRINCETON, NJ 08540
TEL: (609) 921-3555
FAX: (609) 921-3620

☐ Psychological Records	☐ CT of the Head	☐ _____
☐ Medical Records	☐ Chest X-Ray	☐ Records For Period From _____ to _____
☐ Lab Results	☐ EKG	☐ Most Current Records Only

To our patients: this-notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Enforcement of this law began April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTAIN SPECIAL CIRCUMSTANCES.

The following circumstances may require us to use or disclose your health information:

To public health authorities and health oversight agencies that are authorized by law to collect information.
Lawsuits and similar proceedings in response to a court or administrative order.
If required to do so by a law enforcement official.
When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
To federal officials for intelligence and national security activities authorized by law.
To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
For Workers Compensation and similar programs.

YOU'RE RIGHTS REGARDING YOUR HEALTH INFORMATION

Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

You can request a restriction in our use or disclosure of your health information for treatment payment, or health care operation. Additionally, you have the right to restrict our disclosure of your information to only certain individuals involved in your care or the- payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

You have the right to inspect and obtain a co-pay of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office either by mail or fax to the attention of your provider. If you have any questions you may call 609.921.3555

You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practices. To request an amendment, your request must be made in writing and submitted to Mrs. Tiffani Emenhizer. If you need further information call 609.921.3555. You must provide us with a reason that supports your request for amendment

Princeton Medical Institute
Notice of Private Practices

Right to a copy of this no tice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

Right to file a complaint if you believe your privacy rights have been viola ted, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Mrs. Tiffani Emenhizer. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Mrs. Tiffani Emenhizer in our office.

I hereby acknowledge that I have been presented with a copy of HIPPA Notice of-Privacy Practices.

Patient Signature: _____

Patient Print Name: _____

Date: _____/_____/_____
DD MMM YYYY

Princeton Medical Institute
Office Policies and Consent for Treatment

The following information describes my office policies and serves as consent for treatment. I will be happy to answer any questions. This consent will serve as an agreement between us, which either of us may revoke at any time.

Confidentiality: I acknowledge that you will be presenting personal and sensitive information. Information is treated as confidential and privileged and will not be revealed to anyone else without written consent, except under the following conditions:

1) When a child is being abused
2) When someone's life is in danger
3) When collaboration is needed with another mental health professional. If I need to consult with or send reports to health care providers or other outside agencies (e.g., insurance companies, attorneys; schools, etc.), a release of information form must be first signed by you.

Length of Sessions and Fee Policy: Please make every effort to arrive for your scheduled appointment online. Unless there is an emergency, I will rarely keep you waiting. If you arrive late, your session will still end at the scheduled time.

Initial Psychiatric Evaluation	$400.00
Follow Up Visits	$250.00
Medication Management	$160.00
Reports and Letter Preparation	$150.00
Cancellation less 24hrs / No Show	$100.00

Payment: Payment is expected at each session unless advance arrangements have been made. The fee will be .collected at the start of each session. We accept cash, personal checks, VISA/MC/AMEX as forms of payment. We do not work with a sliding scale. Reports and letters are appropriate on an hourly rate of $150.00 with a minimum charge of $150.00.

Cancellations: All appointments are scheduled in advance and that time is reserved for you. A 24-hour notice is required for cancellations, otherwise you will be charged for $100.00. If a true emergency situation occurs (e.g., a death in the family, an accident, or a serious illness) that necessitates less than 24 hours cancellation, the fee will be waived. Please anticipate situations in advance that are not considered an emergency and for which the fee will be charged (e.g., baby sitting needs, difficulty leaving from work, commuting/traffic delays). In the event of a dangerous weather condition, we may provide a telephone or Skype session. Please note that insurance companies do not reimburse for missed appointments charges.

Insurance: You are responsible for the payment of all services. Insurance companies differ as to their coverage. You will need to check with your carrier to determine if treatment is covered and their reimbursement policy. Filing claims and collecting from your insurance company is your responsibility.

Princeton Medical Institute
Notice of Private Practices

Reimbursement from insurance companies should go directly to you unless you have insurance for which we participate in this office. Because of the complexities of insurance coverage, I do not accept direct reimbursement from insurance carriers (other than from those we are credentialed). We will be happy to assist you in completing forms or providing necessary information to your insurance company so that you can receive reimbursement. We will give you a statement receipt after each session for your submission to insurance. Your bill contains all the necessary information required for most insurance carriers.

NOTE: Should we receive payment from insurance, and then it is later determined that you did not qualify for benefits at that time, requiring that we reimburse monies previously received, you will immediately responsible for the FULL amount of the appointments for which services were rendered.

Telephone calls: Our office numbers are as follow:

Princeton 609.921 .3555
Red Bank 732.784.2881.
9:00 am - 5:00 pm, Monday - Friday.

One of our secretaries will be happy to assist you during regular office hours. In the event you have a question that cannot be handled by our secretary, you can leave a message stating you need to speak to one of us and what the matter is regarding. We will make every attempt to return your call within 24 hours, Monday - Friday. If you are calling outside of these hours, please note that voicemail is available but not checked during the evening or on weekends or Holidays. If you have an acute emergency, please dial 91 1 or go to the nearest emergency room.

Termination: Termination is an important part of the treatment process. When completing psychotherapy treatment, it is strongly recommended that you allow at least two (2) sessions to work through the termination process. This permits integration of therapeutic gains and also prevents premature termination due to difficult points or impasses during psychotherapy.

Acknowledgement of Informed Consent: I have read this form, discussed all concerns, and understand the office policies. I fully agree to comply with these policies and consent for treatment by Dr. Olga Tchikindas, MD and/ or Dr. Jeffrey T. Apter, MD.

Signature of Client: _____ Date: _____/_____/_____
(If client is over 18 years or older) DD MMM YYYY

Signature of Parent / Guardian: _____ Date: _____/_____/_____
DD MMM YYYY

Princeton Medical Institute
Office Policies and Consent for Pharmacological Therapy

After an initial psychopharmacological evaluation, medication may be prescribed. The purpose, pharmacological action, proper use of, and potential side effects of your medication will be fully discussed with you.

Typically, your weight and blood pressure will be taken and monitored if you are prescribed medication. Laboratory tests will be initially ordered to evaluate your health status and to determine baseline blood levels and ordered periodically to monitor your health status during the time you are taking the medication. With your consent, I usually like to consult with your therapist and primary care practitioner in order to promote continuity of care.

Medication, for most people, is used primarily to alleviate physica1 and psychological symptoms. In general, medication provides symptom relief, but it does not gel at root causes of problems or provide psychological growth. Psychotherapy is necessary for this, and it is important that you are receiving psychotherapy as well as taking your prescribed medication. Thus, for most people, medication is used as a "bridge" until sufficient psychological growth through psychotherapy is achieved. However, for others, medication may be necessary for long periods of time, especially when there are long-standing biochemical imbalances or chronic psychiatric disorders.

After new medications are prescribed, a second appointment will be scheduled in approximately two weeks. This appointment is to review progress and make necessary adjustments. Weekly to biweekly appointments are then scheduled for approximately the next 6 to 12 weeks. If you are stable on the medication, visits are then scheduled every 3 months. The least often I see people for medication maintenance is every 3 months. This is a necessary requirement to monitor your health status and is a standard of care practice. Please schedule your 3-month appointment at the time of yoi.ir visit. If you do not schedule your appointment at the time of your visit, please call me 2 weeks before you run out of medication to schedule an appointment. Appointments are necessary for medication renewals. This office does not routinely call in medication renewals to pharmacies.

In the event of medication reactions or other urgent questions, please call the office immediately. Your phone call will be returned as soon as possible.

Princeton Medical Institute
Notice of Private Practices

Acknowledgement of Informed Consent: I have read this form, discussed all concerns, and fully understand the office policies for pharmacological therapy. I fully agree to comply with these policies and consent for treatment by Dr. Olga Tchikindas and/or Dr. Jeffrey T. Apter, MD to prescribe and monitor my psychiatric medication.

_____ I give consent for my primary care practitioner to be contacted.

_____ I DO NOT give my consent for my primary care practitioner to be contacted

_____ I give consent for my therapist to be contacted.

_____ I DO NOT give consent for my therapist to be contacted.

Signature of Client: _____ Date: _____/_____/_____
(If client is over 18 years old) DD MMM YYYY

Signature of Parent / Guardian: _____ Date: _____/_____/_____
DD MMM YYYY

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ☐ ☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

This instrument is designed for screening purposes only and not to be used as a diagnostic tool.
Permission for use granted by RMA Hirschfeld, MD

RADAR-PGx Registry defining Adverse Drug Reaction (ADR) improvement measures with medication optimization for therapeutic effectiveness and safety. Medication Management utilizing Pharmacogenomic Testing

The way individuals metabolize medicine is often influenced by their genes. There is a known genetic variance from one individual to another. The study of the role genetics plays in the body's ability to process medicine is called pharmacogenomics.

We are enrolling physicians to assist in gathering data for pharmacogenomic testing (PGx) to help manage subjects medication regimens and assess if testing can have a positive impact in avoiding adverse drug events, hospitalization and emergency department visits.

Primary Objective

To evaluate the use of PG Testing as medical necessity in the management of patients who are under treatment with several drugs with any of the sequences of biochemical reactions, catalyzed by enzymes, know to be influenced by genetic variations in a patient population.

Secondary Objective

To determine if the frequency of adverse drug events is reduced with PGx testing, and evaluate the therapeutic effects of PGx testing on the requirements for emergency department visits and hospitalizations for drug-related adverse events.

Eligible Drug Classes

- Analgesics
- Anti-Infectives
- Antidepressants
- Anticonvulsants
- Antipsychotics
- Benzodiazepines
- CNS stimulants
- Methadone
- NSAIDs
- Proton inhibitors
- Statins
- Vasodialators
- Antiallergenics
- Antiarrythmics
- Anticoagulants
- Anitepileptics
- Antihypertensives
- Barbiturates
- Clopidogrel
- Diuretics
- Muscle relaxers
- Opioids
- SSRIs
- Steroids

Honorarium

An honorarium is available to physicians upon completion of the trial survey for patients enrolled in the study.

Inclusion Criteria

1. Patient is a male or female over 25 years of age.
2. Patient was receiving at least one medication known to be associated with allelic variation at the time of the index PGx test, including over-the-counter medications;
3. Patient has a history of at least one Target Adverse Event (TDAE) over the 24 month period preceding receipt of PGx test results, or has experienced inadequate therapeutic efficacy from a target drug;
4. Patient underwent PGx testing for alleles appropriate to the target drugs within the prior 120 days ("index PGx test");
5. Patient is able and willing to provide written informed consent;

Exclusion Criteria

Patients will be excluded if any of the following criteria apply:

1. Patient is unable to provide an accurate history due to mental incapacity;
2. Patient is currently hospitalized;
3. Patient's medical and medication history is unavailable over the 120-day period preceding the receipt of PGx test results;
4. Subject is known to have undergone prior PGx testing for genes specific to the target drug(s), exclusive of the PGx test relating to this Registry.

Genomic Assessments

The Registry will assess genes associated with a patient's target medications or with substitute medications considered as replacements for target drugs.

Additional genes and variants maybe included in the protocol as the body of knowledge in PGx testing expands.

This is intended as a general overview of the protocol and benefits. If you have questions pertaining to the clinical study, honorarium or administration of testing, please contact your local account manager.